# GUIDES FOR HISTORY TAKING AND CLINICAL EXAMINATION OF PSYCHIATRIC CASES

GEORGE H. KIRBY, M. D.

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# GUIDES FOR HISTORY TAKING AND CLINICAL EXAMINATION OF PSYCHIATRIC CASES

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# PREFACE

Over fifteen years ago Dr. Adolf Meyer, then Director of the Psychiatric Institute, prepared a set of clinical guides or outlines for use in the New York State Hospitals. These were furnished the physicians in typewritten form. Their practical value was quickly recognized with the result that they were adopted as the standard method of clinical study, not only in the New York State Hospitals, but in many other institutions throughout the country. A number of changes and additions to the guides have been made with the passage of time and the advance of psychiatric knowledge, but there has been no departure from the general plan originally formulated by Dr. Meyer for history taking and clinical examination of mental cases.

There has long been a demand that the guides be made available for use in permanent printed form. The decision of the State Hospital Commission to publish the guides gave the editor an opportunity to revise and amplify them in several directions and to add considerable new material which has been accumulated as the result of the experience of recent years.

The guide for the study of the personality make-up is based on the well known work of Hoch and Amsden and follows in a general way the outline prepared by Dr. Hoch for use in the State Hospitals while he was Director of the Institute.

Dr. Clarence O. Cheney, Assistant Director of the Institute, helped materially in the revision, and the guide for the study of body development and the endocrine glands is almost entirely his work. Dr. Charles E. Gibbs of the Institute Staff assisted in revising the anamesis guide.

From various physicians in the New York State service helpful suggestions have been received. The Editor wishes to acknowledge particularly the assistance rendered by Dr. George W. Mills, Clinical Director of the Central Islip State Hospital, and Dr. Mortimer W. Raynor, Clinical Director of the Manhattan State Hospital.

October 1, 1921 G. H. K.

# I

## THE USE OF GUIDES IN CLINICAL PSYCHIATRY

The necessity of following some kind of a plan or method of case-study in psychiatric work is universally recognized. Physicians taking up psychiatry should, therefore, first of all, try to perfect themselves in the art of history taking and strive to develop a good technique for the examination of mental patients. Facility and skill in these directions will be acquired slowly and only after painstaking effort. Method and technique are certainly just as important in psychiatry as in any branch of internal medicine or clinical diagnosis.

Owing to the variety and complexity of the situations dealt with in the investigation of life histories and the difficulties encountered in the examination of many types of mental disorder, the physician who approaches a case without a definite plan in mind is certain to overlook important facts or permit the patient to lead too much in the examination, often with the result that the time is not spent to the best advantage.

One of the chief obstacles in developing a satisfactory scheme has lain in the difficulty of devising guides that would meet the requirements of the widely differing types of cases without at the same time becoming too cumbersome and involved for practical clinical application. Furthermore, the kind of guidance needed by one beginning psychiatric work is quite different from that required by an experienced clinician. One unfamiliar with the guides presented in the following pages will perhaps at first feel that they are too elaborate and go too much into detail; especially is this likely to be the reaction of one who must examine fairly rapidly a large number of cases, a situation which, unfortunately, often confronts physicians in state hospitals. The fact that work must sometimes be done

under conditions unfavorable for the best and most satisfactory results furnishes no valid reason for objection to a method which aims at a higher level of thoroughness and completeness.

The guides present in some detail the various topics which it is essential to keep in mind if cases are to be carefully and adequately studied. It is not expected that one would, even under ideal conditions, undertake to follow out in every case every line of inquiry suggested in the various guides. The guides contain a good deal of information and various tests which should be available when needed. One's experience and judgment must decide how far it is desirable or necessary to push the examination in this or that direction. Thorough familiarity with the guides and the general plan of study outlined will give the physician a solid foundation on which to develop good psychiatric technique and clinical skill, will make the daily work more interesting and valuable, and will qualify him to make special clinical studies and investigations as opportunities arise.

## THE ANAMNESIS GUIDE

(Synopsis)

INTRODUCTION

1. INFORMANT
2. FAMILY HISTORY
3. PERSONAL HISTORY
   - I. Birth and Early Development
   - II. Intellectual and Social Development
   - III. Sexual Development and Function
   - IV. Diseases and Injuries
   - V. Occupation
   - VI. Alcohol and Other Toxic Influences
   - VII. Previous Attacks of Mental Disorder
   - VIII. Etiologic Factors and Precipitating Causes
4. ONSET AND SYMPTOMS OF THE PSYCHOSIS

# II

## THE ANAMNESIS GUIDE

*Introduction.* In the study of mental cases nothing is more important than a good account of the previous history of the patient, the physical and mental development, and the manner in which the psychosis began. Without this information it will be quite impossible in many cases to understand the nature of the disorder or to make a satisfactory diagnostic grouping of the cases. It is therefore essential to devote as much time and care as possible to the obtaining of full and reliable statements from visitors. It requires time and experience to become proficient in this aspect of psychiatric work.

In mental cases the practice should be to try always to get the anamnesis from relatives or friends, as in many instances one cannot depend on the patient for the previous history as is usually done in general medical cases. A number of interviews with the same informant, or with different members of the family, or friends, will in most cases be necessary in order to obtain a correct estimate of the family stock and traits and to get a satisfactory account of the patient's life and mental breakdown. It is particularly difficult to obtain a good anamnesis by means of correspondence or through attendants, although the latter often do very well if an effort is made to train them by some systematic instruction in history taking and in the use of suitable guides or forms. Trained psychiatric social workers may often be of great assistance in getting histories and the physician should not neglect to utilize to the fullest extent the services of the social worker in securing the desired information.

In the following guide various important lines of inquiry are taken up under certain general headings. This is done for purposes of convenience and systematic approach, but

the sequence suggested need not in all cases be followed. It must also be constantly borne in mind that a psychiatric history portrays growth, development and change—a stream of events and the reaction to them, so that an account of the individual as to tendencies or health at one period may be quite different from that of another time of life. There are some advantages in dividing up the descriptions roughly into the periods of infancy and childhood, puberty, adult life, involution, senescence—all of which have special features, physical and mental, that are of great psychiatric importance.

Before the anamnesis is considered complete, all of the topics mentioned should be covered by an appropriate inquiry. But common sense and judgment must be used in deciding just what amount of detailed investigation the different topics call for. We learn by experience where to place the emphasis and in what direction to press our inquiries. The anamnesis of a case of senile psychosis will be taken with a different object in view than that pursued in a case of dementia præcox.

The use of short summarizing headings for the different paragraphs or topics is advised, as these render it easy to get rapidly the salient facts from a case history. The headings should, however, be brief and concise and not simply a somewhat shorter statement of what is to follow in the paragraph.

In cases where there are no relatives or visitors and the patient must give the previous history, it is advised that this be recorded in the usual form of an anamnesis and be placed, as is customary, in the front part of the case record rather than incorporated in that division of the mental status dealing with memory tests and the patient's ability to give personal data. In some cases it will, of course, not be possible to take an anamnesis from the patient until the more disturbed phase of the psychosis has subsided or even until convalescence has set in. Case histories often lose a great deal of their value because no anamnesis was

obtained from the patient before discharge or from the visitor who came to take the patient home.

It is suggested that the physician always have the guide at hand when the visitors are interviewed. In addition the physician should have before him the following:

1. The commitment paper or a typewritten copy of it if the patient is a committed one. It is important to go over the statements of the relatives and the patient contained in the paper. Very often relatives deny statements made to the committing physicians or give quite a different account of happenings preceding the patient's admission than that recorded in the commitment paper.

2. The statistical data sheet (New York State Hospital Form 22-Medical). This should be filled in as far as possible at the time the anamnesis is taken because many of the items require special inquiry if accurate statistical data are to be obtained. It is also important to complete as much of the data sheet at this first interview as possible because of certain information called for in death certificates, in questions of legal residence, in deportation proceedings, etc.

## THE ANAMNESIS

Taken by . Date

INFORMANT:

1. Name
2. Address
3. Relationship to patient
4. Intelligence and reliability

Record any mental or physical abnormality observed in the informant and other relatives seen. Subsequent family history and observations made on relatives may be recorded as an addition to the family history and inserted in the case record.

FAMILY HISTORY:

The family history furnishes evidence as to the hereditary factor as well as the environmental influences. In addition to a history of definite psychosis or nervous disease, it is desirable to secure evidence of the various less direct and specific factors which throw light on the social reactions and intellectual development as well as the physical make-up and defects of the different members of the family. Deviations from normal may not be manifest in the same way in each generation. A member of one generation may show evidence of endocrine disturbance in the form of goiter, while a member of the previous generation may have displayed the disturbed metabolism of diabetes.

It is not sufficient to ask simply the general question: has any member of the family been insane or nervous? A great many persons will answer in the negative, whereas, a detailed inquiry will often bring out a number of instances of nervous or mental troubles. In a similar way questions regarding physical defects and diseases in the ancestors must be as specific as possible. All questions should be put in non-technical terms, and judgment and

discrimination must be used in accepting as a settled fact diagnoses or causes of death as given by the informant. A descriptive statement as a rule is much preferable to a one-word diagnosis.

In orded to cover the ground satisfactorily specific inquiry should be made concerning each member of the family indicated below and the data recorded in the sequence given. If the informant has no knowledge regarding any individual of the given generations, it should invariably be mentioned in order that in our statistical studies we may be able to put together the cases about which we have the facts and exclude those about which we have no information. It is not permissible merely to say that the family history is negative: this rarely if ever can be proven to be true especially if we have complete and reliable data covering several generations. One may, therefore, usually make a statement that the history is negative only in reference to a particular generation or branch.

*The direct line includes*

1. Paternal grandfather
2. Paternal grandmother
3. Maternal grandfather
4. Maternal grandmother
5. Father
6. Mother
7. Children in family, siblings or brothers and sisters of patient. Record in order of birth, including still-births and those dead.
8. Children of patient, give in order of birth.

*The collateral line includes*

Uncles, aunts, and cousins.

The aim should be to obtain as complete information as possible regarding all members of the direct line and to gather as many facts as is feasible regarding the collateral lines. With this object in view, the history of each individual of the different generations, as above indicated, must

be systematically recorded. The data may be conveniently arranged and classified as follows:

1. Name, relationship to the patient, living or dead, age, cause of death, occupation
2. Mental disease: psychosis or suicide
3. Mental deficiency: idiot, imbecile, moron
4. Nervous disease:
   (*a*) Organic: brain tumor, cerebral arteriosclerosis, multiple sclerosis, paralysis agitans, Huntington's chorea, muscular atrophies, etc.
   (*b*) Functional: psychoneuroses, "nervous prostration," acute chorea, migraine, epilepsy, etc.
5. Psychopathic personality: eccentricity, seclusiveness, emotional instability (excitable, depressive, cyclothymic), irritability, stubbornness, suspiciousness, suicidal impulses, nomadism, criminality, sexual perversions, etc.
6. Alcoholism, drug addiction, or exposure to other toxic exogenous agents
7. Physical defects and diseases:
   (*a*) *General*
   Gastro-intestinal
   Cardio-vascular, often referred to as "apoplexy," "stroke" or paralysis
   Renal disease
   Cancer
   Gout
   Asthma
   (*b*) *Infections*
   Tuberculosis
   Syphilis
   Other infections: typhoid, rheumatism, pneumonia, etc.
   (*c*) *Endocrine and metabolism disorders*
   Giantism, dwarfism
   Obesity, abnormal leanness
   Thyroid disease, diabetes

(*d*) *Defects of development* and "stigmata of degeneration," deaf-mutism, albinism, congenital deformities, unusually large or small hands, feet, or head.

PERSONAL HISTORY:

I. *Birth and early development*

Present age Date of birth
Place of birth
Mother's condition during pregnancy
Character of labor Unusual incidents or complications
General health in infancy and childhood: Robust, delicate or sickly
Infantile and childhood diseases Age, severity and complications Injuries Spasms Convulsions
Bed-wetting When stopped
Talked and walked at what age
Disposition as a child Docile, happy, cranky, peevish, fretful Tantrums or fits of temper
Night terrors, fears, frights, chorea
Was growth regular, slow, or rapid
Any special period of rapid growth
Thin or fat
Nose bleeding: Periodicity
Headaches: Character, location, periodicity

II. *Intellectual and Social Development*

Infancy and childhood: bright, dull, or average
School history: years at school, progress, interest, behavior, age and grade at which stopped Play activities and attitude to playmates
Delinquency: truancy, waywardness, tramp-life, police record
Adult intellectual level: well informed or ignorant
General range of interests and social activities
Religious affiliations: devout or indifferent

III. *Sexual Development and Function*

1. Physiologic

*Males.* Age at puberty or when first shaved, or when voice changed Masturbation, when begun how long continued Frequency

Sexual activity: relations with women, character and frequency Single or married, age at marriage, number of children Anti-conceptual measures Any change in sexual power Impotency How long Date of last intercourse

*Females.* Menstrual history Age at onset
Regularity Amount and duration
Preceding symptoms
Associated symptoms
Post-menstrual symptoms
Headaches Character and duration
Masturbation When begun How long continued Frequency
Single or married Age at marriage
Pregnancies Abortions
Number of children Anti-conceptual measures
Menopause: Age and accompanying symptoms

2. Psycho-sexual

Unusual childhood interests or curiosity
Adolescent interests. Abnormal love attachments or perversions
Family situation: strong attachments or antagonisms to either parent, or to other members of the family Special dependence or reluctance to leave home Attitude toward family determined by any special occurrences
Love affairs and disappointments
Sexual irregularities, seduction or prostitution
Reasons for marriage or for single life
Treatment of partner—abuse, separation, divorce

IV. *Diseases and Injuries*

1. General. What sickness has patient had since childhood Were any mental symptoms associated Gastro-intestinal, cardio-vascular, renal, or urinary disorders Gout Convulsions, fainting attacks, migraine

2. Infections

*Tuberculosis.* Evidence of active infection, loss of weight, cough, hemoptysis, weakness, hematuria, pleurisy, adenitis, night sweats, etc.

*Syphilis.* Sore, eruptions, etc. Age when acquired, treatment, symptoms of involvement of nervous system

*Focal and other infections.* Tonsilitis, ulcerated teeth, otitis and sinusitis, rheumatism, heart disease, acute chorea, gonorrhœa, prostatitis, etc. Measles, diphtheria, typhoid, pneumonia, influenza

3. Symptoms suggestive of endocrine and vegetative nervous system disturbances

The information already obtained regarding the family and personal history may have indicated the presence of some endocrine or vegetative nervous system disturbance. In any case the following points should be covered in the inquiry for endocrine disorders:

Abnormal desire for sweets, fats, fluids
Regularity, degree of such desire, and bad symptoms following
Increased urination—day or night
Diabetic symptoms

Investigation of disorders referable to the vegetative nervous system should include the following:

Sensations of heat or cold
Hay fever, asthma, eczema, urticaria
Exhaustion or lassitude
Chills and goose flesh

V. *Occupation*

Kinds of work undertaken, ambition, efficiency, wages, etc. Length of time in different positions, reasons for changes, etc.

VI. *Alcohol and Other Toxic Influences*

Intemperate, moderate, or total abstainer. If intemperate, age at which drinking began, apparent cause of excesses, kind of beverage consumed and approximate amounts. Periodic or steady drinker. Usual reaction to alcohol.

If intemperate, inquire about attacks of neuritis, delirium, hallucinatory episodes, suspicions, ideas of jealousy.

*Other Toxic Influences.* Drug habits, occupational poisons, lead, arsenic, phosphorus, mercury, etc.

Illuminating gas poisoning, nicotine, intoxication, food toxicoses.

VII. *Previous Attacks of Mental Disorder*

Get dates, places where treated, apparent cause, duration of attacks and general character of symptoms.

Associated physical diseases.

VIII. *Etiologic Factors and Precipitating Causes of Present Psychosis*

Often the psychosis appears to have gradually developed in connection with causes, physical or mental, or both, operating over a comparatively long period. In some cases the causes may be indefinite or not easily elicited, but careful inquiry should be made in such instances for possible etiologic factors and an evaluation made of them.

In other cases, however, the mental break-down seems to have come on more or less abruptly as if precipitated by some special occurrence or situation. Especially to be inquired about are:

*Mental Causes* of an emotional nature such as love affairs, sexual episodes, disappointments, reverses, quarrels, separations, deaths in the family, childbirth, etc.

*Physical Causes* such as acute or chronic illness, infection, childbirth, exhaustion, injury, operation, etc.

## Onset and Symptoms of the Psychosis

Take as far as possible a spontaneous account beginning with the date when the first symptoms were noticed in the patient. In this connection particular attention should be given to changes in behavior, in mood, in manner of speech, in attitude toward others and toward work.

The early symptoms may be physical. In an organic brain disease we may find among the first symptoms an eye-muscle palsy, a fainting spell, headache, pains, etc.; in constitutional mental disorders the onset may be associated with prominent physical complaints, e. g., gastro-intestinal symptoms, fussing about health, hypochondriasis, etc.

Inquiry should be made regarding the appearance of suspicions, unusual interests, peculiar ideas and delusions.

Hallucinations in various fields and the reactions to them.

Obtain as much as possible regarding the trend of patient's ideas, topics of conversation and content of hallucinations. What did the voices say? What was seen in visions?

Forgetfulness, impairment of memory, loss of orientation, clouding of sensorium, delirium.

Always inquire regarding suicidal inclinations or attempts, threats of violence, assaults or homicidal tendencies.

Compare informant's statement with those given in commitment certificate.

What treatment was given at home? Name of physician in attendance.

Date on which patient was taken from home to hospital. By what means taken, by whom accompanied, and what was the patient's reaction to the removal?

## THE PERSONALITY

(Synopsis)

Introduction

I. General Intelligence, Knowledge and Judgment

II. Output of Energy

III. General Attitude Toward Environment

IV. Attitude Toward Self: Inner Mental Life

V. Attitude Toward Reality

VI. Mood: Emotional Reactions

VII. Sexual Instincts

VIII. Feeling of Inferiority

IX. Summary of Personality Traits

# III

## THE PERSONALITY

*Introduction.* In taking the general anamnesis, questions of mental make-up and temperamental reactions will naturally be touched upon to some extent. The relation of psychosis to personality is, however, such an extremely important one that it becomes necessary to make a special inquiry into the habitual or preferred mental reactions which characterized the individual prior to the time of the appearance of definite signs of a mental breakdown.

The various traits which together form the ensemble which we call the personality are of complex origin, being determined by instinctive reactions, early experiences and training and a gradual development of mental habits, interests and attitudes. It is of great importance to know something about an individual's customary way of meeting various situations, e. g., whether the preference is for a square facing of difficulties or for evasion, substitution or some sort of escape. It is now well established that the preferred or habitual reactions peculiar to a person tend to appear in accentuated form in the psychosis which thus derives many of its characteristics directly from the constitutional background; from the standpoint of pathogenesis there is reason to believe that preferred reactions often actually serve to guide an individual into a psychosis. We should, therefore, strive to obtain as precise and accurate descriptions as possible of mental traits or tendencies which influence the mental balance for better or for worse.

It is difficult to classify the various traits which we wish to study and it takes time and patience to collect data on which to form an opinion of the habitual reactions of an individual or to fairly gauge the capacity for adaptation and adjustment. In the following guide special attention is devoted to those traits which psychiatric experience has shown to to be worth knowing about and which, when

summed up, give for practical purposes a fair description of the personality.

In the guide the traits to be studied are arranged in eight groups. The divisions are more or less arbitrary and the questions naturally overlap to some extent; no attempt was made to make the inquiries fit into any rigid system of psychological categories. The questionnaire is based largely on the study of Hoch and Amsden to which reference may be profitably made. (See State Hospitals Bulletin, Nov. 1913).

In getting the data it is of course essential to interview the relatives and friends best qualified by personal association with the patient to give the information desired. During the interviews technical terms should be carefully avoided; the informant should describe without being led by suggestive questions. Concrete illustrations of the way the patient acted at certain times or responded to certain situations, are of especial value and should be, whenever possible, incorporated in the study. One should note whether the personal traits studied have undergone changes in the course of life from childhood to puberty or in later years and the involution period. As emphasized by Amsden the personality should not be regarded as something static or fixed; we really have to do with a continuous stream of developing traits and characteristics which vary at different times and in different periods of life. At the same time one may observe deeply-seated or persistent tendencies which make for good or bad reactions.

I. *General Intelligence, Knowledge and Judgment*

The question of intellectual level will probably have been already considered in the general anamnesis. If necessary, the inquiry may be supplemented here along the following lines:

Learning at school easy or hard
Standing in classes / Failure of promotion
Specially smart in certain subjects
Attention and concentration (at school and later)

Education commensurate with opportunities
Good observer  Reason well
Considered to have good common sense
Capable in positions
Quick, impulsive or deliberate in judgments
Definite or vague plans as to career, etc.
Foresight in planning
Practical  Good or bad manager
Use of tools or mechanical devices

II. *Output of energy*

As a child lively and active at play or work—or sluggish and lazy
Naturally talkative or inclined to be quiet or silent
Hard worker, energetic, hustler
Or slow, sluggish, deliberate, or intermediary
Tendency to over-activity—too much push or tension
Over-active or inactive by fits and starts
Interests in athletics, sports, and recreations

III. *General Attitude Toward Environment*

Play freely as a child
Bashful or at ease with strangers
Sociable, easy to get acquainted, many friends
Or distant, aloof, preference to be alone
Selfish, generous, kind-hearted
Tactless, faultfinding, able to work with others or not
Stubborn and insistent about having own way
Trustful or suspicious, holding grudges
Easily offended, see slights when none was intended
Adapt easily to new situations (as when away from home, moving to new places, change of work, etc.)
Any marked differences in behavior in the home or outside
General range of interests, wide or narrow

IV. *Attitude Toward Self: Inner Mental Life*

Reveal much of inner life—personal views, aims, ambitions, mental conflicts, etc.
Frank and open, or reserved, reticent and shut-in
Tendency to talk and unburden self or not

Over-conscientious and particular, or finicky and over-scrupulous
Tendency to shirk, evade, or procrastinate
Honest and truthful or inclined to lie and deceive
Egotistical, vain, proud
Self-reliant—a leader or inclined to be led
Self-assertive or submissive
Courageous or cowardly
Affectionate, demonstrative or cold
Many, few or no friends
Attracted by what qualities in others
Family attachments—strong or slight
Marked fondness or antagonism for any member of family (father, mother, brother or sister, or other relatives)
Any marked change in family ties between childhood and adult life
Reaction to death of members of the family
(See also under Mood)

V. *Attitude Towards Reality*

Matter of fact or unimaginative
Over-imaginative, visionary, daydreaming, phantastic
Dissatisfied with things as they are
Absent-minded
Interest in occult, abstract and mystical subjects
Superstitious
Religious interests
Interest in sciences and natural phenomena
Logical and orderly in thinking Or the reverse

VI. *Mood: Emotional Reactions*

Placid, even-tempered, or phlegmatic
Cheerful, light-hearted, optimistic
Or gloomy, pessimistic, worrisome, looking on the dark side of things
Irritable, easily angered, tantrums and explosive outbursts
Changeability of mood—periods of buoyancy or despondency
Tendency to brooding
Easily frightened
Tendency to anxiousness and forebodings

Sensitive, touchy, grumbling or faultfinding
Reaction to failures, disappointments, business troubles, responsibility, deaths of relatives or friends
On the other hand, reaction to good news, success, pleasure
Crave sympathy in trouble, seem to enjoy discomforts

VII. *Sexual Instincts*

Frank or secretive about sexual matters
Attitude toward opposite sex or own sex
Natural or shy in presence of opposite sex
Many, few or no love affairs
Reaction to disappointments in love
Decided or uncertain when confronted with questions of engagement or marriage
In married life, well adapted
Attitude toward the partner—affectionate and kind, or dissatisfied, faultfinding, irritable and jealous, or domineering —or, on the other hand, very submissive
Desire for children or not
Sexual demands great or small
Potency, psychic impotence, ejaculatio præcox, frigidity
Masturbation—age and frequency
Any perversions
Sexual curiosity—fondness for gossip about sexual matters
Excessive modesty or prudishness
Special demand for neatness, cleanliness or moralizing
Intolerance of sexual topics and easily disgusted
Idiosyncrasies toward food or odors
Special tendencies to cruelty

VIII. *Feeling of Inferiority*

Many of the traits already considered may be related to a conscious or subconscious inferiority complex. Direct or compensatory reactions to somatic and psychic inferiority are manifold. Among the more important the following may be mentioned:

Self-depreciation, humility, social deference, sensitiveness, seclusiveness, dissatisfaction, jealousy, criticism, stubbornness, cowardice, etc.

Selfishness, conceit, self-pity, hypochondriasis, blaming others for one's faults, lack of respect for others, undue emphasis on dislike of sham, etc.

Unusual demonstrativeness, altruism, generosity, courageousness, etc.

IX. *Summary of Personality Traits*

At the conclusion of the inquiry into the make-up a brief summary should be made of the various traits and habitual or preferred reactions which are most characteristic of the individual under consideration.

## PHYSICAL EXAMINATION GUIDE

(Synopsis)


Introduction

I. General Type, Appearance and Condition

II. Thoracic Organs

III. Digestive and Abdominal Organs

IV. Genito-Urinary Organs

V. Nervous System

1. General and Subjective Sensations
2. Cranial Nerves
3. Cutaneous Sensibility
4. Vasomotor and Trophic Conditions
5. Motor Functions
6. Reflexes
7. Myopathies
8. Fibrillary Twitchings
9. Tremor
10. Speech
11. Organic Reflexes
12. Convulsions

VI. Vegetative Nervous System

VII. Endocrine Glands

VIII. Summary of Physical Examination

# IV

## PHYSICAL EXAMINATION GUIDE

*Introduction.* It cannot be too strongly emphasized that all psychiatric cases require a careful physical examination. This is obviously necessary in the first place for the purpose of determining if the patient is suffering from any injury, physical disease, or impairment of general health. But bodily disorders may be, and often are, important factors in causing or maintaining a psychosis and the indications for treatment may depend chiefly on the results of the physical examination. In the second place, a careful physical examination is necessary for the purpose of determining if there are present any signs and symptoms which are characteristic of certain types of mental disorder. The correct diagnosis of the psychosis will in many cases depend largely on the physical findings, particularly in mental conditions due to disease of the nervous system.

Some of the most common and also the most serious mistakes which physicians make are due to their failure to discover and correctly interpret significant physical signs and symptoms in the early stages of various mental disorders.

The lack of cooperation and even opposition to examination which mental patients often exhibit make the task of the physician doubly difficult and not infrequently tax severely his resourcefulness and patience. The method of approach and the technique of examination are, therefore, extremely important matters if satisfactory results are to be obtained from the physical examination of mental patients.

The following physical examination guide presents in condensed form the standard requirements for a fairly thorough examination of the various organs and functions. In some cases additional tests and further investigations will be necessary to clear up complex or obscure conditions.

The amount of time devoted to the different aspects of the examination will naturally vary with the character of the case.

For convenience of bedside work a printed "Outline" or blank may be used, Form 34-Medical. Space is provided on this printed blank for the writing in of the findings which are then copied into the typewritten case record. This blank is based on the guide, follows the same order of arrangement, and covers the minimum requirements for the initial physical examinations of new cases. It is expected that the physician who uses the blank form will also thoroughly familiarize himself with the following "Guide" as this gives helpful directions for making the physical examination as well as some hints of diagnostic value.

## PHYSICIAL EXAMINATION

### I. General Type, Appearance and Condition

1. ***Anthropological Make-up***
   (a) Height Weight (present)
   (b) Malformations and asymmetries: skull, face, ears, palate, body, spine, thorax, pelvis, hands, feet, sexual organs.
   (c) Osseous system: general stature, frame and skeletal type. Abnormalities in height, size of head, face and jaw bones, setting of teeth.
   Disproportion between size of extremities and trunk. Torso-leg ratio (by measurement).

2. ***Nutrition***
   Usual weight: subcutaneous fat, amount and distribution
   Muscles, tone and size

3. ***Skin, Hair and Nails***
   Color and texture of skin, general complexion, color of eyes
   Anæmia, jaundice, bronzing, dropsy, pallor, flushing, cyanosis, eruptions, trophic disorders
   Hair, color, quantity, unusual distribution
   Nails, appearance and condition

4. ***Glandular System***
   Lymphatic, salivary, thyroid, thymus, mammary glands

5. ***Mouth, Teeth and Naso-Pharynx***
   Mucous membranes, tongue, gums, fetor, pyorrhœa
   Teeth, condition and number missing
   Tonsils and adenoids
   Naso-pharynx

6. ***Chronic or Acute Diseases***
   (a) Temperature, pulse and respiration
   (b) Scars, bruises and injuries (to be carefully noted and fully described)
   (c) Evidence of syphilis: scars, mucous patches, glands, tibial crests and exostoses of skull. Date of infection, how treated
   (d) Signs of gout, rheumatism or tuberculosis (other than respiratory)
   (e) Acute infections, local or general signs

## II. Thoracic Organs

1. ***Circulatory Organs:*** Is there any palpitation In attacks Due to what Subjective sensation of arhythmia Dyspnœa Oedema Any attacks of pain or anxiety

   *Heart:* The impulse seen and felt in what area Relative dullness (right, upper and left borders) Give *measurement from median line,* beside the statement as to nipple-line; in pathological cases draw a chart

   *Sounds* and bruits (localized) Pay special attention to muffling of the first sound, to duplication; to change of murmurs on inspiration and by position and to rhythm and accentuation, and indicate graphically sounds and murmurs

   *Radial pulse:* Rate, quality, on lying and sitting and standing Special attention to variability, through position or emotion or exertion If desirable, sphygmogram

   *Condition of vessels:* Radial, brachial and temporal arteries Arcus senilis Sclerosis of veins Varicosities Pulsations of neck

   *Blood pressure:* Systolic and diastolic, lying and sitting Examination of the blood where indicated

2. ***Respiratory Organs:*** Is there any difficulty of breathing, permanent or in attacks Any pain on deep inspiration Any cough or expectoration History of hemorrhage Naso-pharynx obstructions or other abnormalities Larynx, hoarseness or other symptoms

   *Shape and elasticity of chest:* Expansion, frequency of respiration Respiratory movements (compare both sides in deep inspiration and expiration)

   *Lungs:* Palpation, percussion, auscultation Aspiration of pleural cavity when indicated

## III. Digestive and Abdominal Organs

***Appetite,*** thirst, anorexia, nausea; relation to quantity and quality of food Vomiting (time and form); eruptions and brashes; pain (locality, irradiation and time)

***Abdomen:*** Flat, soft, distended, pain, tenderness, rigidity, retraction

*Abdominal organs:* Stomach and liver outlines; gall bladder; spleen; floating kidney

Digestion Movements of bowels Any subjective feeling of obstacles Form of stools Flatulence and distention Constipation, hemorrhoids and fistulas

If indicated—examination of stomach contents and feces

## IV. Genito-Urinary Organs

***Micturition:*** Urine—amount in 24 hours, specific gravity, color, reaction, odor, albumen, sugar and indican and diazo

Macroscopic and microscopic examination of sediment, clouds and threads; casts, epithelia, erythrocytes, leucocytes, bacteria, threads, crystals, amorphous substances (special chart)

***In women:*** Menstruation (regularity and type; duration and amount and probable cause of abnormalities); accompanying symptoms (pains and especially nervous symptoms) Evidences of menopause

Discharges at intervals; constant, profuse, color

Internal examination: findings, their history and possible relation to the rest of the status (Gynæcological chart)

***In men:*** Frequency and character of the sexual functions Frequency of emissions, their exciting causes and correlated symptoms

Masturbation—the reaction to it is the most important point

Penis, scars, ulcers, discharge (make smears if indicated)

## V. Nervous System

1. ***General and Subjective Sensations***

General feeling of well being or exhaustion, general complaints, weakness, etc.

*Vertigo:* Constant, occasional, or occurring on definite changes of position, when the patient walks or in the dark

*Headache:* Whole head or limited space; frontal, vertical, bi-temporal, occipital, constant, or periodic, aggravated at night or by some special cause, as with heat; with or without tenderness of head or spine to touch or pressure

*Pains:* Ovarian, infra-mammary, lumbar and vertex pains (in hysteria)

Neuralgic pains (5th nerve), intercostal nerves, sciatic nerve, with pain points, etc., and muscular pains

General or wandering pains: Præcordial pains with or without anxiety Sudden shooting pains

Pains in bones (legs), afternoon or night

Girdle pains: Zones of hyperæsthesia (See following under 3)

2. ***Cranial Nerves***

*1st Nerve:* Smell Anosmia, paranosmia Test each nostril separately Defects may be mental, nervous or local

*2nd Nerve:* Vision Acuity, dimness, limitation of field, scotoma, hemianopsia, color sense *Eye-grounds* ophthalmoscopic examination Corneal scars Cataract

*3rd, 4th and 6th Nerves:* (Eyelids, muscles and pupils) Test for ptosis, nystagmus, ocular palsies, squint, double vision, convergence, exophthalmos, enophthalmos, size of palpebral fissures

*Pupils:* Size, shape, outlines, adhesions of iris, inequality of pupils Reaction to light and in accommodation; consensual, sympathetic, and psycho-reflexes

*5th Nerve:* (motor portion) muscles of mastication, masseters, temporals, and pterygoids (sensory portion) face and anterior scalp, conjunctiva, mucous membranes

*Taste* anterior ⅔ tongue (see 9th N.)

Neuralgia or facial pains in distribution of nerve should be inquired for

*7th Nerve:* Muscles of forehead, face, mouth and orbicularis oculi

*8th Nerve:* Hearing (cochlear portion) test acuity of hearing Differentiate central, peripheral, and functional deafness Tinnitus and ear noises Unilateral hallucinations of hearing may correspond to diseased ear (vestibular portion) equilibrium, vertigo

*Otoscopic* examination: External canal and drum

*9th Nerve:* Deglutition and sensation back of tongue and upper pharynx

*Taste:* (together with 5th nerve) Test separately anterior ⅓ supplied by 5th N. and posterior supplied by the 9th N.

*10th Nerve:* Test muscles of soft palate and larynx Note disturbances in phonation, respiration and heart action Laryngoscopic examination if indicated

*11th Nerve:* Test action of sterno-mastoid and trapezius muscles Position and movements of the head and scapulæ

*12th Nerve:* Muscles of tongue Protrusion and other movements, atrophy and tremor

3. ***Cutaneous and Deep Sensibility:*** (A few tests of localization of touch and pain sensations obligatory, to exclude hysteria; in all cases with subjective complaints or where any indication and doubt exists, complete examination is advised)

*Subjective complaints:* (formication, feeling of needles and pins, numbness)

*Tactile sensibility:* (use the finger tip, cotton, or pin) Compare both sides of face, arms, hands, fingers, breasts, inner and outer aspects of thighs and legs *Never omit* the ulnar side and the area outside and above the knee, the sole and dorsum of foot and in hysteria the breast and other points of predilection of hysterical anæsthesia

*Localization* of touch (time and space) and tickle

*Sensibility to pain:* (cautious pricks with a pin, localization in time and space), with or without the attention of the patient

*Sensations of heat and cold:* (cold water and warm water in a glass tube) Pain and temperature sense may be lost without any other sensory disorder in syringo-myelia and in lesions of the lateral columns of the cord, and rarely in hysteria These disorders may occur without any other sensory defect

*Stereognostic sense:* Does the patient recognize two or three dimensions, and objects from mere palpation with the eyes closed—of special importance for the study of disturbances of sensory elaboration in the parietal cortex

*Sense of position:* Best studied with the motor functions

*Tenderness of nerve trunks and muscles on pressure and percussion:* The distributions to be noted on the drawings of the body surface

*Biernacki's sign* (analgesia of the ulnar nerve); anæsthesia of eye-ball, of testicles

4. ***Vasomotor and Trophic Conditions***

Salivation, seborrhœa

Cyanosis or pallor; scaliness or glossy appearance of skin; loss of hair; change of nails

Blushing, *dermatographia* General and localized perspiration

*Temperature* of paralyzed or anæsthetic parts

5. ***Motor Functions***

Right or left-handed

Any paresis or paralysis apparent or established by testing the functions of successive segments

Motility of facial muscles (wrinkle forehead, close eyes tightly, show teeth, purse lips, whistle) and movements of jaw, tongue, palate, etc. (See under Cranial Nerves) Test strength of muscles of neck, shoulder girdle, trunk and extremities

*Upper limbs:* Compare hand grips, strength of flexors, extensors and rotators

*Lower limbs:* Rise on toes, elevate toes, flex and extend feet, legs and thighs Elevate both legs from bed and hold to fatigue limit—weaker limb sinks first

*Gait:* Observe walking, turning, stopping and starting Note limping, shuffling, straddling, stamping, ataxia, steppage, propulsive tendencies, etc.

*Coordination:* Writing, buttoning coat and picking up objects Finger-nose, finger-finger and heel-knee tests

*Balancing:* Walk straight line; stand with eyes closed, heels and toes together (Romberg position); steady, sways or falls

*Muscle Sense:* Discrimination of differences in weight; with eyes closed tell the position of limbs; appreciation of passive movements, show by one side the position of the limb of the other side

6. ***Reflexes***

(a) *Deep reflexes:* Masseteric; elbow, wrist, thumb, and knee jerk; latter with or without reinforcement, with clonus, or contralateral adductor reflex; knee cap reflex (tapping the finger which pulls down the patella in the lying position, usually giving a better idea of differences of the two sides) Ankle clonus (one or several catches, or a continuous clonus); Achilles tendon reflex

(b) *Superficial reflexes:* Planter (with full description as to to the Babinski reflex), gluteal, cremasteric, abdominal, epigastric, scapular, corneal, palmar, pharyngeal, sneezing Sexual reflexes (see under 11)

7. ***Myopathies***

Examine carefully weak muscles, or those not responding in reflexes, whether they are firm and of good tone, or flaccid or deficient in tone, or rigid and contracted Note attitude of limb and the limitation of the motion, active and passive, in every joint

Atrophy Hypertrophy

Electrical reactions when indicated of nerve and muscle; mechanical irritability

8. ***Fibrillary Twitchings***

Describe and give distribution

9. ***Tremor***

Of what parts, face, tongue, fingers, etc. Describe as to rhythm, intensity, rapidity

Condition at rest, during sleep; when first observed

Condition during motion, how influenced by will

*A sample of writing* should always be obtained and inserted in the history, (name, date and test phrase)

10. ***Speech***

Note any defect in ordinary conversation

Speech tests are to be tried in every case (third riding artillery brigade; particular popularity; electricity; Methodist Episcopal; army reorganization; truly rural)

11. ***Organic Reflexes and Their Control***

*Bladder:* Delay of micturition Dribbling from empty bladder, from distended bladder Peculiar sensations on micturition

*Sexual reflexes:* Frequent involuntary contraction and evacuation

*Defecation:* Is the patient conscious of evacuations

12. ***Convulsions***

*Duration and frequency:* Occurring night or day, or in early morning Initial cry, scream or other symptoms Extend over head, trunk and extremities, or one side or one member

*Character:* Which parts first and most attacked and how do the waves of the tonic and clonic spasm spread What movements predominate Is a paralyzed part omitted or involved

Observe breathing; pupils; vasomotor conditions; whether there is frothing and biting or talking during attack Relaxation of sphincters

*Consciousness* totally or partially lost

*Aura:* Character, location and spread

Equivalents with or without what automatic movements

Psychical and nervous symptoms before and after attack

Vomiting, headache, sleep, coma

## VI. The Vegetative Nervous System

Supplies the involuntary or smooth muscle organs. Evidence of disturbance infunction may have been observed in the preceding examination of the voluntary nervous system and viscera. It is advisable, however, to call attention here to some of the more striking signs and symptoms which are considered to indicate alteration of function of the vegative nervous system. Among these are:

(a) *Sympathetic Division:* Signs of over-activity are warm, dry skin; wide pupils; rapid heart; hyper-sensitiveness to adrenalin (a sympathetic stimulant)

*Cervical Sympathetic:* Paralysis gives characteristic symptoms; drooping of lid without loss of voluntary control; small pupil, not dilating when shaded, but contracting to light; enophthalmos, with narrowing of fissure; loss of cilio-spinal (sympathetic) reflex; failure of pupil to dilate under cocaine

(b) *Autonomic Division:* Signs of over-activity are cool, pale, moist skin; small pupils; slow heart; gastric hyperacidity; sluggish bowel action; hyper-sensitiveness to pilocarpine (a vagus stimulant)

## VII. Endocrine Glands

Evidence of disturbances may have been found and recorded under other headings. But such evidence may be brought together at this place to focus attention on important symptom-complexes. The special guide for the study of endocrine disorders should be used in suitable cases or where special investigation of the body development and endocrine system is undertaken.

*Thyroid*

(a) *Hyperthyroidism:* tachycardia; tremor; perspiration; gastro-intestinal over-activity; eye symptoms; excessive reaction to adrenalin (Gœtsch test); low carbo-hydrate tolerance.

(b) *Hypothyroidism:* (1) Myxedematous type shows brady-cardia; skin, hair and nail changes; gastro-intestinal sluggishness; high carbohydrate tolerance; diminished reaction to adrenalin. (2) Cretin type shows mental and physical deficiency with symptoms of myxedema.

*Pituitary*

(a) *Hyperfunction*—Onset after puberty gives acromegalic type; enlargement of bones; thickened mucous membranes; enlarged tongue; muscular atrophies; super-abundant hair; alteration in sexual functions; reduced carbo-hydrate tolerance.

Onset before maturity gives giant type: increased length of bone; precocious development of sexual instinct and organs of reproduction.

(b) *Hypofunction*—(Frœhlich's Syndrome) with obesity; general deficiency of hair; infantile sexual organs; short stature; increased carbohydrate tolerance.

*Testicle*

*Hypofunction:* eunuch type shows absence of testicle; obesity; feminine hair distribution; lack of development of external genitalia.

Eunuchoid type shows deficiency of secretion; essentially same signs as in eunuch.

*Ovary*

*Hypofunction:* Delayed puberty; infantile uterus; delayed or dirordered menstruation; obesity.

*Adrenal*

(a) *Hyperfunction:* ( ? ) increased blood pressure; low carbohydrate tolerance; glycosuria.

(b) *Hypofunction:* Skin pigmentation; low blood pressure; asthenia, (Addison Syndrome).

*Status Lymphaticus:* (Related to thymus or adrenal?) Slender frame; feminine contour; feminine hair distribution; smooth skin; hyperplasia of lymphatic system.

## VIII. Summary of Physical Examination

The physical findings are to be summarized not merely in the order of examination but especially in order of importance or evolution and in differential diagnosis. Symptoms which make up a characteristic symptom-complex should be grouped together in the summary. Attention should be called to points for further investigation.

Indications for treatment should be added.

## BODY DEVELOPMENT AND ENDOCRINE GLANDS

(Synopsis)

Introduction

1. General Development: Height, Weight, Body Contour, Nutrition.
2. Head: Face, Eyes, Glabella, Nose, Ears, Jaws, Palate, Teeth.
3. Neck: Thyroid Gland.
4. Spine
5. Thorax
6. Abdomen
7. Pelvis
8. Extremities
9. Muscular Development
10. Skin
11. Hair
12. Cardio-Vascular System
13. Lymphatic System: Tonsils and Other Lymphoid Structures.
14. Sexual Organs
15. Subjective Sensations
16. Drug Reactions: Pilocarpine, Atrophine, Adrenalin.
17. Laboratory Tests: Blood, Sugar Tolerance, X-Ray.
18. Endocrinopathies in Family
19. Developmental History: Growth, Weight Changes; Sexual Function, Etc.
20. Summary of Findings

## V

## BODY DEVELOPMENT AND ENDOCRINE GLANDS

*Introduction.* This guide is offered tentatively for use in special investigation of body development and of the glands of internal secretion to supplement the usual physical examination guide. It is not meant to take the place of this latter, but is intended to give in more detail directions for investigating the relation of body development and endocrine make-up to physical or mental disease. Form 128 medical is a printed blank or outline based on the guide and is intended for use in the individual clinical examinations or bedside work in about the same manner as the printed blank Form 34 medical, is used in making the ordinary physical examination.

This guide and the outline (Form 128 medical) should be supplemented in individual cases by information obtained in the anamnesis regarding the physical characteristics and susceptibility to disease of the family and also the developmental history of the patient.

In arranging the guide the standard textbooks and various special articles have been consulted; most assistance has been obtained from the publications of Dr. Walter Timme, including the examination scheme devised by him and used at the New York Neurological Institute.

1. General Development: Careful estimation of the height of the patient is to be made. The trunk length is the length in inches between the suprasternal notch and the anterior superior spine of the ilium. The leg length is the length in inches between the anterior superior spine of the ilium and the internal malleolus.

In a properly proportioned person the leg length is twice the trunk length (torso-leg ratio). It has been observed that in hypo-function of the pituitary the trunk is comparatively longer than the extremities; in deficiency of the

internal secretion of the sex glands it has been observed that the leg length is longer in proportion than the trunk length. Certain other relations between these measurements may be noted with other developmental or endocrine abnormalities.

The arm span is the distance between the right and left middle finger tips when the arms are extended horizontally sideways, and in well proportioned individuals approximately equals the height. About the same disproportion between the arm span and the height has been noted as in the torso-leg ratio in the conditions mentioned above. The arm span measurement is perhaps best taken by having the patient stand with the back to the wall, the extended arms in a sideways horizontal position, with the middle finger-tip of one arm at the zero point on a scale in inches; the opposite middle finger-tip marking off the span distance.

*Weight:* A variation from the usual weight may indicate not only chronic visceral disease but also an alteration in endocrine function; for example, an increase or loss of weight may indicate decrease or increase of thyroid function, an alteration of function of the sexual organs or of the pituitary.

*Body Contour:* Is to be noted as masculine or feminine as the relation of shoulders, waist and hips and the inclination of the thighs and angularity or roundness of contours suggest the masculine or feminine type of development.

*Nutrition:* To be noted as poor, fair, good, obese. This indicates the amount of subcutaneous fat, which may be influenced by not only environment and economic state or visceral disease, but also by endocrine activity. For example, emaciation may be the result of adrenal hypo-function or thyroid hyper-function; increased amount of fat the result of sexual gland hypo-function or obesity with thyroid or pituitary hypo-function. The distribution of the subcutaneous fat is to be noted as even, a comparatively

normal state, or if uneven, the locations of the accumulations of fat, particularly of the breasts, abdomen, pubis, hips or extremities are to be mentioned.

2. Head: Circumference is to be taken with a tape passing through the external-occipital protuberance and across the forehead. The average circumference in the male is said to be about 52 cm., female 50 cm., with a normal variation between 48.5 cm. and 57.4 cm. (Church & Peterson's Nervous and Mental Diseases, 1916 ed., p. 699). It is said that the volume of the brain may be estimated from the circumference by considering 50 cm. (20 inches) as equalling 1,350 cc. of volume. (The formula would be—volume : circumference : : 1,350 cc. : 50 cm.).

The length is best taken by calipers and is the widest antero-posterior diameter. Average male 17.7 cm., female 17.2 cm., normal variations 16.5 cm. to 19 cm.

The width is the greatest transverse diameter. Average male width said to be 14.6 cm.; female 14 cm., normal variations 13 to 16.5 cm.

The cephalic index is gotten by dividing the width by the length, and the head is described as dolichocephalic (long head) if the result is less than 78, mesocephalic if between 78 and 80, and brachycephalic (short head) if greater than 80. It is said that the physiological limits of the index are 70 to 90.

*Type of Face:* Here are to be noted not only the general shape of the face (long or narrow, broad or short) but also the characteristics indicating the acromegalic, the infantile, the cretinoid, the prematurely aged (gerodermic) and Mongolian types.

*Eyes:* Note the comparative prominence of the eyeballs, whether normal, or protruding, as in exophthalmic goitre, or whether receding or deep-set (enophthalmus) a condition which may be found either bilaterally or unilaterally in paralysis of the cervical sympathetic. Exophthalmos is to be considered, on the contrary, to be due to the stimulation of the cervical sympathetic.

Inter-pupillary distance has so far as known no set standard, but the width or narrowness of this space is indicative of the type of osseous development.

The palpebral fissure is to be noted in its width and equality, or inequality, either of which may be indicative of abnormal thyroid or sympathetic function. The movements of the eyelids may lag in sympathetic stimulation; in cervical sympathetic paralysis there may be a pseudo-ptosis with drooping of the eyelids without loss of voluntary elevation.

*Glabella:* The glabella, supra-orbital ridges and malar eminences are to be noted as to their prominence which indicates a type of bony development, particularly marked in giantism or acromegaly; the prominence is less marked in pituitary hypo-function.

*Nose and Ears:* Note as to size and form or shape; also abnormalities and asymmetries in the ears.

*Jaws:* The upper and lower jaws are to be described as protruding, straight or receding. These characteristics apparently vary with alteration in function of the pituitary. Their width also varies possibly with the function of the same gland.

*Palate:* Describe as to its height with abnormalities, particularly the presence or absence of maxillary *torus,* an elevation of bone in the mid-line, supposed to be indicative of pituitary abnormality.

*Teeth:* Particular attention is to be paid to the spacing or crowding which is indicative of the type of bony development. The condition of softness or hardness of the teeth and their preservation may also indicate deficiencies of development or endocrine disturbance. Pigmentation, if found, is thought to be indicative of adrenal dysfunction.

3. Neck: Describe as short, long, thick, thin, with circumference noted in inches. The long, thin neck is found in the hyper-thyroid or thymic type of case, and the short, thick neck is possibly associated with pituitary dysfunction

or thyroid hypo-function. The thyroid should be carefully palpated and described. Note the presence or absence of a thrill and bruit, often present in hyper-function of the gland.

4. Spine: Normal or abnormal, particularly with regard to scoliosis, lordosis or kyphosis, and if such conditions are present determine whether they are due to actual bone disease or to lack of muscle tone. This lack of tone may be found in deficient adrenal states or in the asthenic stages of acromegaly or in primary pituitary hypo-function.

5. Thorax: The long, narrow, flat type, or the short, thick or barrel-shaped type. Persons with these types are said to be variously susceptible to physical disease and to have deficient endocrine functions. The narrow sub-costal angle usually goes with the long type of thorax and the wide angle with the short type. The circumference on inspiration and expiration indicates definitely the relative size of the chest compared with the rest of the body, as well as the pulmonary capacity and function.

6. Abdomen: Note the type, whether scaphoid, or moderately rounded with firm muscle, or dependent and obese the last not infrequently found with pituitary hypo-function and indicative of lack of muscle tone. The girth of the waist indicates the relative size of the chest and abdomen.

7. Pelvis: Masculine or feminine in type, and perhaps best definitely to indicate this are widths at the crests and the width at the trochanters. The inclination of the thighs should be observed.

8. Extremities: The proportionate development of the extremities to the trunk should be noted, not so much as to length, which has been described under 1, but as to the type of bone. Particular attention should be given to the relative proportion of the hands and feet to the upper portions of the extremities. The distal portions of the extremities in acromegaly are disproportionately enlarged. The reverse

may be true in hypo-pituitarism. The type of hand or foot is indicative also of the type of body development and possibly of endocrine function. The arch of the foot, whether high, low or flat, may indicate muscle tonus.

9. Muscular Development: Describe the general muscular development as poor, fair or good. Relative development of trunk and extremities should be observed. Rapid muscle fatiguability as brought out by arm setting-up exercise is particularly evident in case of hypo-function of the adrenal or in cases of status lymphaticus. This latter condition may depend on the former.

*Atrophy or Hypertrophy* should be noted and fully described if present.

*General Muscle Tone:* Investigate and note the presence or absence of hyper-extensibility of the various joints, the latter indicating a lack of muscle tone frequent in hypo-function of the pituitary.

10. Skin: Should be described as dry, or moist, or oily; warm or cool; smooth or rough; thick and course or thin and fine; or myxedematous; with the location of the various abnormalities, if present, on the face, neck, trunk, arms, hands, legs or feet.

*Perspiration* should be described as to its amount and whether uniformly distributed or localized in certain parts of the body, such as the face, axilla, hands, perineum or feet.

*Flushing:* Present or absent, general, or localized to certain parts of the body.

*Pallor:* To be investigated the same way.

*Urticaria* or the presence of goose flesh and any type of eruption should be fully described.

*Reaction on stroking:* Determine by moderately firm stroking with the ball of the index finger on the thorax or abdomen. The normal reaction is a red line; a red line with a white border is said to indicate moderate adrenal insuf-

ficiency, and an entirely white line (Sergent's Line) a more marked degree of this condition.

*Complexion:* Note whether albino, blond, light brunette or dark brunette; is said to be of possible significance for resistance to disease and for endocrine make-up.

*Pigmentations* of various parts of the body, including mucous membranes and points of pressure from the clothes, may be found in adrenal disease.

*Nails* whether smooth, rough, fissured or brittle, may indicate endocrine abnormalities. The hyper-thyroid type is said to have smooth, pink nails; the hypo-thyroid type of nail is of a dry, brittle character.

11. Hair: The character, that is, whether downy, fine or coarse, and the amount, whether absent, sparse, thin or thick, of various portions of the head, trunk and extremities, are to be described as indicating the possibility of endocrine dysfunction. For example, the acromegalic type is frequently hairy. A marked excess of thick, coarse hair is also found in disorders of the cortex of the adrenals. The deficient sexual gland type may have thick hair of the head, but a deficiency elsewhere on the body, whereas the hypo-pituitary type has a thin, sparse distribution of hair throughout.

12. Cardio-vascular System: In this examination acquired organic disease of the heart is not considered, but rather the functional cardiac action as determined by inspection, palpation and auscultation. One may describe the action as weak or feeble, or normal, or excessive.

Very important is the investigation of the blood pressure, both the systolic and diastolic. Not only one reading but second and third readings should be taken after about two or three minutes intervals. By this method variations over brief periods in the systolic and diastolic pressures are frequently noted, such variations perhaps being most marked in the hyper-thyroid types and in adrenal insuf-

ficiency, perhaps in status lymphaticus. The pulse in both reclining and standing positions is to be noted. Also important as indicating the functional activity of the heart is the increase in the pulse rate after moderate setting-up exercise of the arms, with observations as to the time required for the heart to return to its previous rate. A lack of prompt return after exercise indicates cardiac irritability or nervous instability (possibly hyper-thyroidism).

Cyanosis of the hands or feet should be noted as indicating poor circulatory function.

13. Lymphatic System: The condition of the tonsils, adenoids, and axillary, epitrochlear and inguinal lymph-nodes should be noted, these being enlarged perhaps particularly in cases of status lymphaticus, although apparently not necessarily so. Thymus enlargement may be ascertained by percussion or X-ray.

14. Sexual Organs: In the male the testes should be described, whether descended or undescended, and their size noted, and also their consistency, particularly to determine atrophy with a fibrous condition. This latter alteration has been described as present frequently in dementia præcox, a claim which needs to be checked up. The size of the scrotum may indicate the general muscular tone of the body, being particularly lax and dependent in cases of hypo-function of the pituitary. It may of course be quite small in deficient sexual development. The latter statement also applies to the penis.

*Female:* Careful gynecological examination is to be made to ascertain particularly the size of the uterus and the development of the external genitalia. The condition of the menstrual function is also to be carefully noted, obtaining, if possible, the history regarding this.

15. Subjective Sensations: It is considered advisable to note, if obtainable from the patient, subjective bodily sensations, particularly cold, warm, or hot sensations in the

skin, constant or variable, including hot flashes. Feelings of general weakness or easy fatigue, and abnormal desire for sweets, or excessive thirst, should be investigated. Other subjective sensations referable to the vegetative nervous system or the endocrine glands may suggest themselves.

16. Drug Reactions: Variations in the reactions to drugs which have a more or less specific effect upon the vegetative nervous system have been described as indicating the state of irritability of the sympathetic or autonomic portions.

*Pilocarpine,* for example, has been considered to be a stimulator of the autonomic portion. It increases sweating, salivation, and other digestive fluids, and movements of the intestines. It has been said that when "a sub-cutaneous injection of one centigram of nitrate of pilocarpine produces salivation and sweating more abundant than normal" (Laignel-Lavastine), an increased irritability ("vagotonia") of the autonomic system is indicated. This test may be carried out by injecting 1-7 gr. of nitrate or hydrochloride of pilocarpine.

*Atropine* is looked upon as having a paralyzing effect upon the autonomic system. It dilates the pupil, tends to inhibit gastro-intestinal secretions and perspiration, and increases the heart rate by lessening the vagus inhibition. It is maintained that when "a sub-cutaneous injection of one milligram of neutral sulphate of atropine produces a rapid and prolonged dilatation of the pupil with considerable increase of the pulse rate," an increased irritability of the autonomic system is again indicated. This test may be carried out by the injection of 1-75 gr. of atrophine sulphate.

*Adrenalin* is looked upon as a stimulator of the sympathetic system and it has been claimed that when "a subcutaneous injection of one milligram of adrenalin produces glycosuria in excess of 5 grams, when the quantity of urine

is doubled and the pulse has a rhythm 1-3 above normal," an increased irritability of the sympathetic system ("sympathicotonia") is indicated. This test may be carried out by the injection of 1 c. c. of a 1-1000 solution of adrenalin. More recently it has been maintained by Gœtsch that hyper-thyroidism is indicated when the injection of .5 cc. of a 1-1000 adrenalin solution is followed after several minutes by an appreciable rise in the systolic blood pressure and fall in the diastolic pressure, and an increase in the pulse rate with a gradual return to the previous pressure and pulse rate after one and a half to two hours, and with increase in symptoms of nervousness and tremor. It is believed by him that the increased thyroid secretion in such cases sensitizes the sympathetic system so that adrenalin injection promotes an excessive reaction.

The significance of the reactions to injection of these drugs does not appear to be as yet finally determined; obviously it is difficult to standardize a normal reaction. It is urged, however, that investigation of the reactions be carried out to promote knowledge regarding their significance in conjunction with the other methods of examination of the nervous system and the endocrines.

17. Laboratory: *Blood count with differential:* Complete blood examination with hemoglobin estimation and differential count should be carried out. It is recommended that the Dare or the Sahli method of hemoglobin estimation be utilized rather than the more simple Tallquist method because of their greater reliability. It has been observed that cases of endocrine disorder not infrequently show a relative lymphocytosis with a leucopenia. It has also been suggested by a recent observer that the presence of a relative lymphocytosis indicates a developmental and physical inferiority. These claims need further investigation.

*Sugar Tolerance:* The power of assimilation of glucose without the production of a glycosuria varies in different individuals and appears to be rather closely related to en-

docrine disease. The amount of sugar that can be so assimilated is spoken of as the sugar tolerance. This has been found to be high in such conditions as myxedema, pituitary hypo-function, adrenal hypo-function and sexual gland deficiency, and to be low in hypo-function of the pancreas and in hyper-function of the thyroid and the pituitary. The average individual is able to tolerate about 200 grams of glucose. Tests are carried out by giving, therefore, to an individual whose urine has been found previously to contain no sugar, 200 grams of sugar with coffee or water on a fasting stomach. The subsequent 24-hour urinary output is examined for the presence of sugar; preferably, tests for the presence of sugar are made one, two, and three hours after the ingestion to determine the time of appearance of glycosuria if present. Subsequent tests with large or small amounts of glucose may be carried out according as 200 grams result in the absence or presence of glycosuria.

*Blood Sugar:* The test for the blood sugar content is generally considered to indicate more satisfactorily the power of assimilation by the body of carbohydrates. The test can be carried out after the manner of Benedict-Lewis, Folin or Einstein, as described in works on physiological chemistry (for example, Hawk's Practical Physiological Chemistry, 1919). High blood sugar content in general is found in cases with low sugar tolerance and vice versa.

*X-ray:* A complete endocrine and bodily development examination should include an X-ray examination, particularly of the head, so as to determine the size and shape of the pituitary fossa; evidence of calcification of the pineal; the condition of the teeth, particularly with reference to lack of development or lack of eruption; and the condition of the sinuses, particularly with respect to their size, as indicating type of bony development. X-ray examination of the epipyses of the extremities, especially the hands, brings out the presence or absence of retarded bony development; such examination also demonstrates bony overgrowth.

18. Endocrinopathies in Family: It is considered advisable to include in the examination of the patient whatever account may be obtained from the patient regarding types of development in the ascendants, particularly the presence of giants or dwarfs, thin or stout persons, and other evidence of endocrine disease, such as goitre, diabetes, and sexual gland deficiency. This does not exclude, of course, inquiry from members of the family regarding these conditions made in the regular anamnesis.

19. Developmental History: Likewise, it is considered advisable to obtain from the patient, if possible, a description of the character and rate of the personal development with special reference to rapid changes in weight or height. Previous subjective bodily sensations and sexual desire and potency should be investigated. Any other information of significance for endocrine disease obtained from the patient should be carefully noted.

20. Summary: At the end of the examination a brief descriptive summary should be made, indicating the type of body development, with enumeration of the signs and symptoms pointing to disturbance of one or more endocrine glands or of the vegetative nervous system. An opinion as to the source or nature of the abnormal condition or conditions found should be expressed and indications for treatment, if any, should be noted.

## MENTAL EXAMINATION

(Synopsis)

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# VI

## MENTAL EXAMINATION

***Introduction.*** The first principle in the observation of mental disorder is to describe accurately and to present the facts so that they can be used in chains of cause and effect. In our descriptions we must get unequivocal statements, learn to avoid all terms which are open to confusion; and wherever we are in doubt about terms, we do best to resort to a plain statement of events in simple, non-technical language. This does not prevent our using in our judgment all the available knowledge, but it does keep us from getting involved in a terminology which is often deceptive and tends to make us think that we know more about the case than the actual facts warrant.

It is usually little important that a patient does or says a certain thing; but that he does or says *it in a definite setting,* gives the act or utterance the value of adequacy or inadequacy of normal or abnormal working. Hence the important rule in recording clinical observations, that wherever there is anything peculiar to be demonstrated, it is necessary to give the facts in their natural connections, and very often it is desirable to report conversations in *question and answer* form on the ground that a reaction can not be judged without a knowledge of the provoking agent.

This does not mean that the entire examination is to be reported in question and answer form, a procedure very rarely necessary. Records are often overloaded with questions and answers and apparently this method is sometimes followed because it seems the easiest way out, or because of inexperience or lack of appreciation of what a record should contain. As a rule the verbatim account should be limited to those questions, answers, and reactions which characterize a type or serve the differential diagnosis.

On the other hand, many records are almost valueless because they give chiefly the examiner's impressions and

judgments without recording scarcely any of the facts on which the conclusions are based. It is especially desirable to give in the patient's own words examples of the delusional ideas entertained and the hallucinatory experiences if any are described. (Such examples also may be valuable in certain cases in relation to medico-legal questions). The general rule is that the record should contain a sufficiently full report of what the patient actually said and did to permit the reader to form an independent opinion of the case as a whole or of the various reactions shown by the patient.

One must be prepared to spend much time and effort in acquiring a good technique of examination and in learning how to present the facts with proper regard for their psychiatric worth.

In the direct examination of the patient the mode of approach is absolutely decisive of the result. The reserve of the patient is often very great, or if not the reserve, at least the unwillingness to show a clear picture of peculiar experiences. It is, therefore, necessary to gain the confidence by treating the patient as a "sensible man or woman." In most cases it is positively essential to interview the patient privately; the statements can then usually be obtained quite freely, often with a feeling of relief to the patient, and a distinct gain in the relation between physician and patient.

That any chances for self-humiliation must be eased with verbal suggestion and that any appearance of obnoxious ridicule or dictation or correction and unnecessary argument must be avoided, should not require special insistence. The feelings of the patient, the general situation and the special idiosyncrasies are to be kept in mind before all. The utmost care is necessary to make the patient feel that all is done in a spirit of helpfulness. The establishment of a comfortable and wholesome relation of patient to physicians and nurses should be the keynote of all our efforts. It is very striking how much more composed and

amenable to explanations and conversations many patients are *just on admission,* than they are only a few hours or a day or so later, especially if there is any tendency towards mutism or confusion. One should, therefore, proceed with the examination at the earliest possible moment.

Physicians often make the mistake of waiting for a disturbed, delirious or negativistic patient to become quiet and freely accessible before undertaking the investigation of the mental condition. It is, however, just as necessary to proceed with the examination of an excited, delirious or stuporous patient as it is with a quiet or cooperative one. The examination must of course be shaped according to the condition of the patient, but *a good record of the reactions, moods, utterances, etc., during the stormy or non-cooperative period of the psychosis is of the utmost importance.* In fact, it is just these pathological reactions that require the most painstaking study and description. It is, therefore, inexcusable to adopt the plan of waiting for the disappearance of such symptoms before attempting to make an examination.

It is very difficult to give definite directions regarding the mental examination and at the same time avoid the danger of producing records which are merely formal descriptions of various more or less detached aspects of the case with failure to show the sequence of events and the driving forces in the development of the abnormal condition and without which we cannot get a clear picture of the working of the patient's mind. For purposes of order and systematic approach it becomes, however, necessary to adopt some general plan of work and to arrange our observations under certain topical headings. These are selected because they cover the most important manifestations of mental disorder and have a value in differential diagnosis.

The order of arrangement suggested in this guide is not necessarily best followed in every case. We have to be governed by the condition of the patient and the examin-

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ation, as mentioned above, must of course be shaped according to the type of disturbance under investigation. The experienced physician stresses that part of the examination which obviously deals with the most important aspects of the case before him.

It is advised that in recording the results of the examination under each division of the guide, use be made of short, concise summarizing headings, in capitals, in order to indicate and emphasize what the important findings are in each one of the various sub-divisions.

I. ATTITUDE AND GENERAL BEHAVIOR:

We begin with a brief description of what the nurses and we ourselves observe in the patient, a common sense picture of the patient's conduct and reaction to the situation. This includes the general demeanor since admission, or since the last note, with special reference to the variations of activity and mood.

The general description should cover the following: Does the patient look sick, weak or strong; in bed or up; peculiarities in dress; degree of self-care shown; neat or untidy; personal habits and cleanliness. How does the patient react to the ward-life and routine? General mood, calm, elated, or depressed. Adaptable or not? Compliant, resistive or assaultive? How is the time spent, in working, reading or in idleness? Sociable or seclusive; how spontaneous in conversation, talks on what topics?

In practice it is best to write or dictate this division of the mental status at the conclusion of the examination for the reason that the "Attitude and General Behavior" should include a description of what is observed *during the interview,* particularly in reference to the following:

General conduct, cooperation and attention under examination; manner, speech or posture; the facial expression and general appearance which may show anxiety, fear, bewilderment, perplexity, exaltation of spirits, irritability, changeability of mood, etc. Or there may be displayed distrust,

conceit, ecstasy, beatitude, absorption, etc., dilapidated, silly conduct.

A close analysis of the *motor activity* is extremely important and will often afford important points for differential diagnosis. In case there is *hyperactivity,* describe a series of motions or acts, giving the sequence of events as faithfully as possible. In this way we can recognize flights of activity, busy purposeful activity, nervous restlessness, stereotyped, senseless motions, automatism, aimless fumbling.

Examine resistive or non-cooperative patients for negativism, muscular tension, stiffness, catalepsy, suggestibility, automatic obedience, etc.

In states of *reduced activity* we observe loss of initiative or lack of spontaneity or slowness in action. Make special tests for motor retardation, e. g., counting, walking, dressing, etc. Retardation may be initial or general.

In *stupor* we have a complete lack of responsiveness and general immobility. A careful examination should be made, using the special guide for non-cooperative or stuporous patients, page 81.

II. STREAM OF MENTAL ACTIVITY:

This is best studied in the patient's spontaneous account of his trouble or, when this is not given, in the reactions to special questions. This gives us an idea of the spontaneous productivity and of the nature of the stream of thought. Obtain *verbatim* samples of the stream of mental activity which is always necessary if there is any peculiarity in the verbal reactions or utterances of the patient.

The patient may exhibit *no disorder* in the spontaneous conversation; may answer questions promptly, relevantly and show logical progression in association of ideas.

The patient may be *over-productive* in speech and show volubility, rambling talk, abnormal divertibility, flight of ideas, incoherence, verbigeration or disjointed, scattered utterances. Or with or without over-productivity there

may be distractibility of attention, sound associations, peculiar expressions, self-invented words or phrases (neologisms), irrelevancy, echolalia, stereotypy, etc. It should be borne in mind that disturbances in the stream of thought (flight, incoherence, irrelevancy, etc.) may not appear at once or in response to the first few questions. They may appear at some subsequent part of the examination to which reference should be made so that the reader can find the samples. Often disturbances in the stream of thought will be brought out only when the patient's delusional trend is touched on. Distractibility and flight in elaborations may often be demonstrated by simple tests, such as showing objects, making sounds, speaking certain words and requesting the patient to give a series of associations.

The patient may show a *diminshed productivity,* give few or only an occasional utterance, or there may be a marked slowness in speech with evidence of retardation in the mental processes, or the patient may refuse to speak or to answer any question—mutism. In case the patient seems inhibited or retarded, indicate the approximate time to obtain a response, observe whether or not the answer when once started is given rapidly or with slowness, hesitation or pauses. (Differentiate between an initial or a general consistent retardation).

When the patient is spontaneously productive, we note down at once samples of the stream of thought and then follow this by a few questions such as are suggested below. The replies are put down as far as possible just as they are given, so that it becomes possible to form a picture of the actual stream of mental activity and attention.

1. What is your name?
2. What do you do?
3. Do you know where you are?
4. Do you know why you are here?
5. What trouble have you had?

These few questions may already confront us with a great difficulty in the further examination. The patient may be inaccessible,

as in the states of coma, stupor, delirium, excitement, self-absorption, or indifference, and we must be satisfied with making a good description of the attitude and general reactions and noting the merely fragmentary replies; *or* the responses may show the other extreme—that of profusion of activity or speech, and here again about the only thing we may expect will be fragments which however, may be eminently characteristic and therefore must be faithfully recorded.

In these cases it is particularly necessary to be familiar with the special disease pictures. There is, however, a fair number from whom a more or less satisfactory spontaneous account can be obtained.

After the situation is ascertained and an idea formed as to any disturbance in the stream of thought, the general clearness and accessibility, and the patient's competency to give an account of the mental disorder, proceed to the next topic for investigation.

III. EMOTIONAL REACTION: AFFECT AND MOOD:

Since abnormalities of the emotions are among the most striking manifestations of mental disorder, a careful analysis of the affective reactions is extremely important. The emotional state will, of course, have to be considered especially in relation to the mental trend and the general activity of the patient, but at some point in the examination it is advisable to give particular attention to the mood, and to describe just what deviations are observable in this direction. In general we may note the objective and subjective aspects of the emotional reactions: what we see, the facial expression, the attitudes and postures, and what the patient tells us as to his feelings.

We note whether the patient is quiescent, composed, complacent, or without any special emotional display.

Or irritable, angry, happy, elated, exalted.

Or boastful, egotistical, self-satisfied.

Or suspicious, distant, disdainful.

Or depressed, sad, hopeless, anxious, fearful, perplexed.

Or indifferent, apathetic, dull.

Often there is striking variability in mood, changeableness, etc., with or without apparent external causes.

Of special importance is the relation between affect and thought content. We should note carefully any inappropriate emotional reactions or discrepancies between the patient's ideas and the accompanying mood. A dissociation may be indicated by an indifferent, smiling, or silly reaction in the face of ideas which would normally call forth a depressive, anxious, or distressed affective response.

Even where the patient is unresponsive (or mute) we may make important observations as to the affect by noting the behavior of pulse and respiration, or the appearance of flushing, perspiration, or tears, or changes in facial expression, etc.

If the feelings are not spontaneously described by the patient, appropriate questions may be asked, as:

1. How do you feel?
2. Are you happy?
3. Are you indifferent? Satisfied?
4. Are you sad? Troubled over something?
5. Are you afraid?
6. Are you worried?

In most cases the examination will now have furnished sufficient facts to recognize the general drift and the nature of the mental state, whether it belongs to the delirious, the essentially delusional, the emotional, or one of the deteriorating organic types. The questionnaire and the amount of verbatim notes should be adapted so as to take in with special care the points of differentiation—positive and negative—in terms of simple tests wherever any doubt might be foreseen. It is so easy to acquire a very plausible vocabulary that one must over and over insist on this rule.

## IV. MENTAL TREND: CONTENT OF THOUGHT:

We may have already learned from the preceding parts of the examination a good deal as to the patient's general mental trend, whether or not delusional ideas or hallucinations are present. We desire now to deepen our inquiry and to study carefully the origin and elaboration of any

peculiar ideas, abnormal trends, special undercurrents, and hallucinatory experiences.

The patient may be willing and able to give a good account of the beginning and subsequent course of the mental disorder. He should, therefore, have an opportunity to *tell his story in full.* In delusional states the main emphasis will fall on this part of the status. The patient should be encouraged to talk freely and to recount in detail the steps in the development of any suspicious, morbid trend or delusional ideas. The aim should be to get a full report of the patient's trend and as far as possible this should be arranged in chronological order. In hospital or committed cases the patient's account of just what led to admission should be obtained and particular inquiry made as to any anti-social acts or tendencies.

If, as is often the case, the patient is reluctant to talk or inclined to conceal his ideas, we proceed with appropriate questions along the following lines:

If there are indications of a *persecutory trend* we ask concerning:

(a) Sensitiveness of being watched. (Delusions of reference)
(b) Suspicion of being talked about.
(c) Inclination to see a meaning in things.
(d) Unpleasant family relations, jealousy, suspicions of sexual nature.
(e) Suspicions of being wronged, annoyed, robbed, poisoned.
(f) Feelings of bodily influence by machines or electricity, or mind-reading, hypnotism, etc. How is it done and why? By whom? (See also pseudo-spontaneity and passivity). Blocking of thought? Interference with thinking?
(g) Is there a combined plan in all this?
(h) What makes you think so? (Systematization, retrospective falsification).

*Hypochondriacal ideas* or somatic delusions may be brought out by appropriate questions as to health and strength, functions of the internal organs, bowel action, sexual power, condition of the blood, etc.

*Ideas of unreality* may be expressed by feelings that the outside world has changed, that everything looks different, or that the individual has changed, that the body is unnatural, feelings gone, life has ceased, is no longer a human being, etc.

*Nihilistic ideas* may be expressed by statements that everything is lost or destroyed, nothing exists, there is no life, no matter, no universe, etc.

*Other depressive trends* will usually be indicated in the paragraph on Emotional Reactions, although self-accusatory ideas and feelings of guilt may be rather difficult to bring out. Inquiry should be made regarding tendency to self-criticism and depreciation, ideas of sinfulness and self-condemnation, of the soul being lost, etc.

*Grandiose ideas* are more apt to be freely expressed in exalted emotional states. A few questions may be put concerning ideas of strength, power, wealth, high birth, etc.

A suspicion of *hallucinatory experience* leads to the questions:

1. Has anything strange happened?
2. Have you imaginations?
3. Do you have peculiar thoughts?
4. Do you hear things?
   Have you heard any talking from the neighbors, or people on the street?
5. Do you see things?
6. Have you been disturbed at night?
7. Do you dream much?

Frequently it is best to make direct inquiries about more or less positive evidence of hallucinations and delusions in the behavior of the patient. We may find the patient listening and mumbling or gesticulating; or he may suddenly

turn, guard himself, become sullen, or talk. The record must, however, limit itself carefully to what evidence can actually be gained. The current term "talking to imaginary persons" is very frequently not referable at all to hallucinations, especially in manic states. Visions, fear of poison, hallucinations of smell and of physical influence call forth similarly characteristic reactions.

*Combined hallucinations* are most frequent in episodes of fright and terror, in dream-states and deliria with marked disorder of sensorium.

Any such experience of sense deceptions, influence, etc., are to be subjected to a careful analysis along the following lines:

*In the case of hallucinations of hearing:*

1. Do you hear voices? or noises?
2. Where and when? On what occasion? In which ear? (may be unilateral)
3. Whose voice?
4. Plainly? Real voices, sounds or thoughts?
5. In conversation, to, or about you?
6. Do you respond? Do they surprise, affect and scare you?
7. Does your tongue move?
8. Can you stop the talk, or can others? By speaking, listening to other things? What brings it on? Is it worse at times?

In the case of *visual hallucinations,* inquire whether they occur in plain daylight, or dark, with the eyes open or shut: in any special direction: do they move and fit in with the rest, seem natural? Are they transparent or not? Have they color? Are they recognized? Can artificial hallucinations be provoked (pressure of the eye, gazing at a blank?)

Are there any hallucinations of *smell, taste or contact, or organic sensations?*

*Are there illusions and misinterpretations?*

Is there any *organic foundation* for sense deceptions?

Do the sense deceptions of various senses cooperate (as in dream-states and dream-hallucinations of the alcoholic and epileptic deliria?)

Do they depend on special affects or episodes?

Are there any *reflex hallucinations* (coming on merely in certain circumstances, such as emotion—and then uniform?) Any pseudo-hallucinations (recognized as imaginations?)

Hypnagogic hallucinations (occurring just when falling asleep or at the moment of awakening).

Has the patient insight into the hallucinations at the time, or afterwards?

In the case of *"peculiar thoughts":*

1. Do you have strange thoughts?
2. How do they come to you?
3. What about?
4. Many kinds, or mostly the same?
5. In what relation to what you think, or to what others say or do?

*Pseudo-spontaneity or passivity:*

1. Do you do anything queer and strange (talk or think or act?)
2. How do you account for it? Are there any imperative thoughts or acts? Pre-occupations? Obsessions?

In order to get at the dynamic factors underlying abnormal emotional reactions and to trace out the origin and significance of the trend, it is usually necessary to have repeated interviews and finally to make a careful analysis of the entire material. This further study must often extend over a considerable period and the results will naturally have to be recorded in continued notes made subsequent to the mental status. (See Further Psychological Analysis, page 78).

## V. SENSORIUM, MENTAL GRASP AND CAPACITY:

In all cases inquiry in this field is essential in order to establish an estimate of the extent of temporary or permanent mental disorganization of the capacities and resources of the individual and the existence and origin of any thinking disorders. Neglect in this direction is the most common defect of many records of cases in whom an error of diagnosis must subsequently be admitted. Especially the records of non-recognized organic conditions, particularly paresis, show very often that a thorough search for gaps of memory and for discrepancies of chronological data has not been made. In these cases actual samples of speech and writing are required to establish defects. Moreover, where the patient has been found unable to give a spontaneous account, the questions here proposed will very likely bring out the most important and most valuable responses on which to base diagnostic conclusions and comparisons with subsequent conditions shown by the patient.

The following questions indicate the lines along which inquiries should be pushed. In cases where something definite is to be demonstrated, the question and answer form of recording results is preferable. In other cases the patient's responses are given as fully as necessary in the form of indirect discourse.

### 1. ORIENTATION AS TO TIME, PLACE AND PERSON:

1. What place is this? What house? What is it for?
2. Where is it located? What city?
3. What is the date? Year? Month? Day of month? Day of week?
4. What time of day is it?
5. Does the patient recognize the examiner as a physician? Identify patients and nurses as such?

### 2. DATA OF PERSONAL IDENTIFICATION, REMOTE MEMORY:

The following questions are aimed primarily to test the grasp of the more remote experiences and the ability to correlate dates and give facts in chronological order. Some

physicians prefer to go further and use these questions, supplemented by others, as a basis for an account by the patient of his life history, a sort of anamnesis. There is no objection to proceeding in this manner if it is understood that a regular anamnesis from relatives or friends is to be obtained and recorded in the usual way as soon as possible.

If the patient is capable of giving reliable information the physician may at this point turn to the statistical data sheet and fill in as much of the information called for as is deemed desirable. It is especially important to do this in patients who have no visitors or friends, as the information called for is needed for administrative purposes, statistics, and death certificates.

1. Where were you born?
2. Date of birth?
3. How old does that make you?
4. Where and how long did you go to school? Highest grade completed?
5. When did you begin work? Name and address of first and subsequent employers?
6. If the patient is foreign-born, ask:
   When did you come to the United States?
   With whom? On what ship and line?
   How old were you then?
7. Naturalized citizen of the U. S.? If so, give date and particulars.
8. How long in New York State?
9. Date of marriage? How old were you then?
10. Names and birthdays of children?
11. Where were you last employed? Name and address of employer?
12. In what other hospitals treated? Give the dates?
13. Family data: names and birthplaces of parents; living or dead; suffered from what peculiarities or diseases. Number of children (brothers and sisters of patient), what peculiarities or diseases shown by these.

3. MEMORY OF THE RECENT PAST:

1. Where do you live? Street and number? With whom?
2. How long have you lived there?
3. When did you leave home?
4. Where did you go, and with whom?
5. How did you come here? How did you travel here?
6. Who came with you?
7. What was done for you on admission?
8. How many days here?
9. Where were you yesterday? A week ago?
10. How many meals have you had today?

4. RETENTION AND IMMEDIATE RECALL:

1. Give for retention a street address and a person's name and show a color, an object, and the time on the watch. Test after 5 *min.*, 1 *hour* and 1 *day.*

2. Repeat immediately digits in series. (Give the first and fourth series and others if indicated).

| | |
|---|---|
| 4-6-9-2 | 7-3-8-4-6-9-2 |
| 5-3-8-1-7 | 8-2-9-6-4-7-1-5 |
| 2-9-6-4-8-3 | 3-5-1-7-4-6-9-2-8 |

Record the result of the tests and show how far the patient can go without mistake. If there is any question of a retention disorder additional tests can be carried out as follows:

3. Execution of series of orders: Marie's three-paper test as follows:

> Use 3 pieces of paper of different sizes and give different instructions for disposal of each, e. g., throw the largest piece out of the window, put the middle-size piece in your pocket and give me the smallest piece.

4. Word pairs. Let the patient repeat the ten pairs and then ask him to give the second word of each pair when the first is repeated to him.

| | |
|---|---|
| Head—hair | Window—door |
| Room—hall | Book—pencil |
| Chair—table | Lake—river |
| Grass—tree | Apple—pear |
| White—red | Pipe—tobacco |

5. COUNTING AND CALCULATION:

1. Count 1 to 20 as rapidly as possible.
2. Count backwards 20 to 1.
3. Count coins.
4. Simple calculations:

| | | |
|---|---|---|
| 4 times 9? | 5 and 4? | 12 divided by 6? |
| 6 times 16? | 14 and 9? | 63 divided by 7? |

Begin with 100 and subtract successive 7's.

5. Year and one-half interest on $200 at 4 per cent.
6. If 5 times X equals 20, how much is X?

*In all the tests* give the *time required* in seconds or minutes, so that comparisons can be made later. Also describe the effort made by the patient to cooperate, and if there are delays, slowness or errors, how does the patient explain them? *Any feeling of mental insufficiency?*

6. READING:

A short story or paragraph with subsequent rendering of the contents: Can the patient get the point of a story, grasp the sense and retain the detail? Or does he show flight in elaborations, etc.? For routine test the "Cowboy Story" is suggested. The patient reads the story and is then asked immediately to tell what it was about.

A cowboy from Arizona went to San Francisco with his dog which he left at a friend's while he purchased a new suit of clothes. Dressed finely, he went back to the dog, whistled to him, called him by name, and patted him. But the dog would have nothing to do

with him in his new hat and coat but gave a mournful howl. Coaxing was of no effect so the cowboy went away and donned his old garments, whereon the dog immediately showed his wild joy on seeing his master as he thought he ought to be.

7. WRITING:

Name, address and date, also some dictated sentence, such as: "This is a beautiful September day."

Slow, constrained or free?

Show omissions or transpositions of letters or syllables? (Important in suspected paresis).

Mannerisms?

8. THINKING CAPACITY, ATTENTION AND MENTAL TENSION:

The foregoing tests will usually furnish data on which to base an estimate of the patient's ability to think, concentrate, fix the attention and to correlate dates and facts of experience. Evidences of temporary interference with capacities, with activization of memories and with mental tension should be noted, with examples.

Some additional tests may be given for attention and capacity of grasp, as follows:

1. Lines of digits or letters are read aloud to the patient who is required to tap each time a certain digit or letter occurs. Or the lists may be given to the patient with the instruction to cross out the designated digits or letters. (See Franz: Mental Examination Methods, page 71).

Any printed page may be used and the patient instructed to cross out the specified letter. (Number or letter checking tests).

2. Heilbronner test: Outlines of various familiar objects drawn with varying degrees of completeness are shown for recognition. (Franz, p. 80).

9. SCHOOL AND GENERAL KNOWLEDGE:

In some cases it is desirable to investigate the ability to reproduce what was learned at school and also to test the range of the patient's general information and grasp of current events. The tests, of course, should be made with due regard to nationality, educational level, and general

experiences of the individual. Tests already made under Counting and Calculation, Reading, Writing and Thinking Capacity, will have given a good deal of information as to school knowledge and mental level.

If there is any evidence that the patient is illiterate, mentally deficient, or markedly deteriorated, the following simple questions may be given:

1. What grade did you reach at school?
2. Repeat the alphabet? (In English or native language).
3. Give the days of the week? The months?
4. How do you spell chair? bridge? hospital? conductor?

If there are no indications for giving the above tests, the examiner may proceed at once with the following historical or geographical questions which should be readily answered by anyone who has passed through the grammar school in this country:*

1. When and by whom was the Declaration of Independence made? (July 4, 1776, the Continental Congress of the 13 original colonies).
2. When was the Civil War? What was it about? (1861-5, the right of secession and abolition of slavery).
3. Name the oceans.
4. Five largest cities in U. S. (or the patient's native country).
5. Where is Brussels? Rome? Havana? Moscow? Pekin?
6. What is the Gulf Stream?

The following may be used as tests for general knowledge and grasp of current events: (Questions No. 4 and No. 5,

* For persons educated in foreign countries the first two questions should be replaced by equivalent questions relating to the history of the native country. All of the other questions in this section are suitable for foreigners who have had the equivalent of a grammar school education.

may not be considered suitable for foreigners unless they understand English and came to the U. S. prior to 1917).

1. Who invented the steam engine? The phonograph? Wireless telegraphy?

2. Can you explain what causes the seasons? Why is it warm in summer and cold in winter?

3. What was the immediate cause of the world war? Tell what nations fought on each side?

4. What were the last two amendments to the Constitution of the U. S.?

5. What do you understand by the phrase "Make the world safe for Democracy?" Who first used it?

10. INTELLIGENCE RATING:

The intellectual level of the patient may be judged to a considerable extent by the results of the preceding parts of the examination. If there is reason to suspect that the individual is sub-normal in intelligence, a psychometric determination is indicated. This of course cannot be done satisfactorily unless the patient is accessible and cooperative.

Great care must be exercised in judging the results of a psychometric test in the presence of a psychosis. In some psychotic states, because of the abnormal emotional reactions, lack of effort, inattention, inhibition, negativism, delusional ideas, etc., a mental age rating would be quite misleading or worthless.

In cases suitable for testing it is recommended that use be made of the Stanford revision of the Binet-Simon scale (a modified form for which is supplied by Utica State Hospitals Press) and of Healy's performance or construction tests.

A good plan is always to give a few intelligence tests as a routine during the mental status. These will yield considerable information as to the intellectual abilities and help in determining whether additional special tests are advisable or not. For this purpose any or all of the fol-

lowing tests, which can be fairly rapidly given, are suggested:*

1. *Healy's Construction Test* A.
   This is carried out by means of a small standard form board and is a 9 or 10-year level test.
2. *Healy's Construction Test* B.
   Requires another type of form board and is a 11 or 12-year level test.
3. *Differences between a president and a king.*
   This is a 14-year level test in the Stanford Binet-Simon scale. "There are three main differences between a president and a king, what are they? (Accession, tenure, power).
4. *Reversing hands of a clock.*
   This is a 14-year level test. "Suppose it is 22 minutes past 6 on the clock; can you see in your mind where the hands are? Suppose the hands are shifted—the long hand turned to the place of the short hand and the short hand to the place of the long hand. What time would it then be on the clock?
   If a second trial is given use 10 minutes past 8 o'clock.
5. *Interpretation of fables.*
   An average adult test in the Stanford Binet-Simon scale. The fable, "The Fox and the Crow," *is read aloud to the patient* and the question then asked: What lesson does that teach?

"A crow, having stolen a bit of meat, perched in a tree and held it in her beak. A fox, seeing her, wished to secure the meat, and spoke to the crow thus: "How handsome you are! and I have heard that the beauty of your voice is equal to that of your form and feathers. Will you not sing for me, so that I may judge whether

* The physician should be thoroughly familiar with the approved methods of giving these tests, the scoring and the interpretation of the results. For description and directions see: Healy and Fernald, Psychological Monographs, Vol. 13, No. 2, March, 1911; Healy, The Individual Delinquent, p. 830; Terman, The Measurement of Intelligence.

this is true?'' The crow was so pleased that she opened her mouth to sing and dropped the meat, which the fox immediately ate.''

After the patient has answered the question: what lesson does that teach: Then the examiner should ask: Have you heard that before?

6. *Differences between abstract words.*

An average adult test. What is the difference between:

Idleness and Laziness?
Poverty and Misery?
Character and Reputation?

7. *Repeat six digits backwards.*

An average adult test. The following two series may be used: 4-7-1-9-5-2; 5-8-3-2-9-4.

11. INSIGHT AND JUDGMENT:

The questions here concern the patient's judgment of the situation, appreciation of the physical and mental conditions, need for treatment, etc.

Does the patient realize that he has suffered a mental change or breakdown? Acknowledge that he has had wrong ideas or imaginations?

Is the patient sensitive to errors made, appreciate defects of memory or other failure of capacity?

What are the plans in case of discharge?

## VI. SUMMARY OF THE RESULTS OF THE MENTAL EXAMINATION:

A concise summary of the main findings established during the mental examination should now be made. The positive features should be emphasized with special regard to symptom-complexes and diagnostic considerations. In functional cases an attempt should be made to specify as far as possible the psychogenic factors and mental mechanisms involved in the evolution of the disorder.

# VII

## FURTHER PSYCHOLOGICAL ANALYSIS

As mentioned on page 68 an understanding of the dynamic forces underlying the emotional and trend reactions and the psychogenic mechanisms at work in a given case requires a number of interviews and a careful sifting of all the data available. In addition to what is established by the anamnesis and study of the make-up, and by the analysis of the mood and mental content as outlined in the mental status, an effort should be made to investigate as thoroughly as possible the conscious and unconscious wishes and conflicts of the patient and their relation to the development of the psychosis.

This should include a painstaking study of the earliest affective experiences and their influence on later developments; investigation of any persistent infantile interests or unusual attachments; a careful probing for submerged or dissociated complexes, and for repressed instinctive desires or individualistic tendencies which stand in conflict with the main or socialized personality—any or all of which may prove to be factors of dynamic importance in the development of psychoneurotic or psychotic manifestations. Material that is definitely beyond the range of conscious memories may be disclosed in suitable cases by the one or other of the following methods:

1. *Free association:* With relaxation of attention and without inhibition the patient is encouraged to give consecutive associations of ideas just as they come into consciousness without any regard to sense, logic or chronological order. In this way we may ask the patient to associate to any aspect of the trend or any idea which is prominent in the psychosis.

Much may be learned of unconscious trends from a study of the utterances of excited or incoherent patients where the inhibitions are to a large extent removed and free asso-

ciation has sway. In such cases one should, therefore, make a record of the productions, stenographic if possible, in order to get good samples of the type of associations and of whatever topics or dominant trends appear in the psychosis. These productions should be gone over with the patient when more accessible or when convalescent. A great deal that comes out in the psychosis may, of course, subsequently be partially or completely repressed.

2. *Hypnosis:* . The more pronounced mental cases are rarely suitable subjects for hypnosis, but the psychoneuroses and milder psychoses may often be investigated by this method. The object is to get at subconscious mental trends or conflicts of which the person is not aware in ordinary states of consciousness. Hypnosis is especially valuable as a means of clearing up psychogenic amnesias by re-attaching dissociated memories to consciousness.

3. *Dream analysis:* As the dream content, in adults at least, is drawn largely from the unconscious, it affords material for study of the unconscious mental life. Dream analysis may, therefore, supplement in an important way the study of psychotic trends and other abnormal mental reactions.

The technique of psychological analysis and detailed directions for case study cannot be gone into here. The physician should become as soon as possible thoroughly familiar with the literature on this subject. The following books and articles are especially recommended: "Mental Mechanisms" by White; "A General Introduction to Psychoanalysis," by Freud; "Technique of Psychoanalysis," by Jelliffe; "Psychogenic Factors in the Psychoses," Hoch, Psychological Bulletin, Vol. 4; "Study of Benign Psychoses," Hoch, Johns Hopkins Bulletin, Vol. 26; "Mental Mechanisms in Dementia Præcox," Hoch, Journal Abnormal Psychology, Dec., 1910.

## EXAMINATION OF NON-COOPERATIVE OR STUPOROUS PATIENTS

(Synopsis)

I. General Reaction and Posture

II. Facial Movements and Expression

III. Eyes and Pupils

IV. Reaction to What is Said or Done

V. Muscular Reactions

VI. Emotional Responsiveness

VII. Speech

VIII. Writing

IX. Somatic Reactions

# VIII

## EXAMINATION OF NON-COOPERATIVE OR STUPOROUS PATIENTS

The difficulty of getting information from non-cooperative patients should not discourage the physician from making and recording certain observations. These may be of great importance in the study of various types of cases and give valuable data for the interpretation of different clinical reactions. It is hardly necessary to say that the time to study negativistic reactions is during the period of negativism, the time to study a stupor is during the stuporous phase. To wait for the clinical picture to change or for the patient to become more accessible is often to miss an opportunity and leave a serious gap in the clinical observation. Obviously it is necessary in the examination of such cases to adopt some other plan than that used in making the usual mental status. The following guide was devised to cover in a systematic way the most important points for purposes of clinical differentiation.

I. GENERAL REACTION AND POSTURE:

(a) Attitude voluntary or passive.

(b) Voluntary postures comfortable, natural, constrained or awkward.

(c) What does the patient do if placed in awkward or uncomfortable positions.

(d) Behavior toward physicians and nurses: resistive, evasive, irritable, apathetic, compliant.

(e) Spontaneous acts: any occasional show of playfulness, mischievousness or assaultiveness. Defense movements when interfered with or when pricked with pin. Eating and dressing. Attention to bowels and bladder. Do the movements show only initial retardation or consistent slowness throughout?

(f) To what extent does the attitude change? Is the behavior constant or variable from day to day? Do any special occurrences influence the condition?

II. FACIAL EXPRESSION:

Alert, attentive, placid, vacant, stolid, sulky, scowling, averse, perplexed, distressed.

Any play of facial expression or signs of emotion: tears, smiles, flushing, perspiration. On what occasions?

III. EYES:

Open or closed. If closed, resist having lid raised.

Movement of eyes: absent or obtained on request; give attention and follow the examiner or moving objects; or show only fixed gazing, furtive glances or evasion. Rolling of eyeballs upward.

Size and play of pupils (hippus?)

Blinking, flickering, or tremor of lids.

Reaction to sudden approach or threat to stick pin in eye.

Sensory reaction of pupils (dilatation from painful stimuli or irritation skin of neck).

Corneal irritability (with or without appearance of tears).

IV. REACTION TO WHAT IS SAID OR DONE:

Commands: show tongue, move limbs, grasp with hand (clinging, clutching, etc.).

Motions slow or sudden.

Reaction to pin pricks.

Automatic obedience: Tell the patient to protrude the tongue to have pin stuck into it.

Echopraxia: imitation of actions of others.

V. MUSCULAR REACTIONS:

Test for rigidity: muscles relaxed or tense when limbs or body is moved. Catalepsy, cerea flexibilities. Nega-

tivism shown by movements in opposite direction or springy or cog-wheel resistance.

Test head and neck by movements forward and backward and to side. Test also the jaw, shoulders, elbow, fingers and the lower extremities.

Does distraction or command influence the reactions?

Closing of mouth, protrusion of lips (schnauzkrampf).

Holding of saliva, drooling.

Sphincters: retention of urine and bowels, soiling and wetting.

VI. EMOTIONAL RESPONSIVENESS:

Is feeling shown when talked to of family or children? Or when sensitive points in history are mentioned or when visitors come?

Note whether or not acceleration of respiration or pulse occurs; also look for flushing, perspiration, tears in eyes, etc.

Do jokes elicit any response?

Effect of unexpected stimuli (clap hands, flash of electric light).

VII. SPEECH:

Any apparent effort to talk, lip movements, whispers, movements of head.

Note exact utterances with accompanying emotional reaction (may indicate hallucinations).

VIII. WRITING:

Offer paper and pencil. Irresponsive or partially stuporous patients will often write when they fail to talk.

IX. SOMATIC REACTIONS:

(a) Temperature, pulse, respiration.
(b) Blood pressure.
(c) Vasomotor reactions: skin warm, cool or greasy; cyanosis, flushing, dermatographia.
(d) Skin reflexes.

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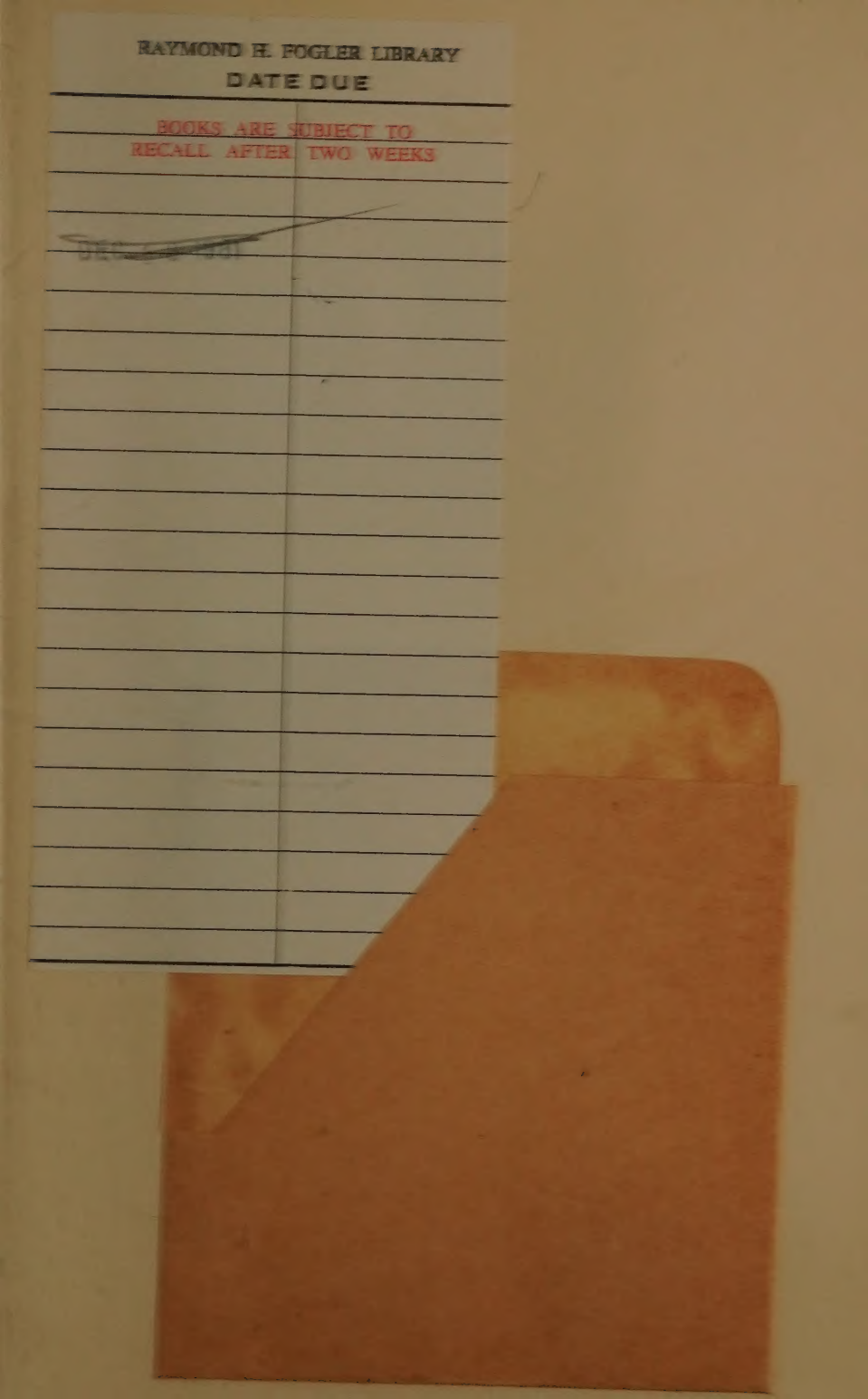

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